State of Washington

PACT 101

Program of Assertive Community Treatment Team Training

THE WASHINGTON INSTITUTE
FOR MENTAL ILLNESS RESEARCH & TRAINING

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Today's Objectives

To learn about...

- What PACT is (and is *not*)
- The evidence base for PACT
- Current plans for WA-PACT implementation
- Anticipated plans for WA-PACT fidelity monitoring

What is PACT?

A Brief History of PACT

- Late 1960's at Mendota Mental Health Institute in Madison, WI
- Stein & Test (1980):
  - Many who were discharged were readmitted later
  - Transferred intensity & support of an inpatient setting into community & directly provided mix of services
- Also known as ACT, continuous treatment teams, mobile treatment teams

Overview of PACT

- An evidence-based practice (EBP) for adults with severe and persistent mental illness
- A team-based approach to providing treatment, rehabilitation, and support within the community
- Focus is on working collaboratively with consumers to address their full range of needs
  - ✓ Obtaining housing
  - ✓ Securing benefits
  - ✓ Community activities
  - ✓ Improving skills
  - ✓ Working with families
  - ✓ Gaining employment

What PACT is NOT

- Traditional office-based program
- A typical program with weekly meetings & informal communication
- An intensive case management model
- A program for people in group homes
- A housing program
- A program that “makes” or forces people with mental illness to do anything

PACT Service Principles

- Transdisciplinary team
- Team approach/ shared caseload
- Specific admission criteria
- Primary provider of services
- Comprehensive care
- Intensive services
- Services provided in-vivo
- Individualized services
- Assertive, yet flexible
- Open-ended service
- Person-centered/Recovery-oriented
- Work with natural supports

Adapted from Morse & McKasson, 2005

	Multidisciplinary	Interdisciplinary	PACT (Transdisciplinary)
Assessment	Separate assessment by each team member	Separate assessment with consultation from other team members	Team members conduct comprehensive assessment together
Consumer Participation	Consumers meet with individual team members	Consumers meet with team or team representative	Consumers are active & participating team members
Service Plan Development	Individual team members develop separate plans for disciplines	Individual team members share separate plans with each other	Team members and consumers develop plans together
Service Plan Implementation	Individual team members implement part of plan related to their discipline	Individual team members implement their section & incorporate others sections where possible	Team members jointly responsible for developing & monitoring integrated plan

Woodruff & McGonigel, 1988

	Multidisciplinary	Interdisciplinary	PACT (Transdisciplinary)
Lines of Communication	Informal lines	Periodic case-specific team meetings	Regular team meetings with ongoing transfer of info, knowledge, & skills shared among team members
Guiding Philosophy	Individual team members recognize the importance of contributions from other disciplines	Individual team members willing & able to develop, share, & be responsible for providing services that are part of the total service plan	Team members make a commitment to teach, learn, & work together across disciplinary boundaries in all aspects to implement unified services plan
Staff Development	Independent within each discipline	Independent within as well as outside of own discipline	An integral component of working across disciplines & team building

Woodruff & McGonigel, 1988

WA-PACT Staffing Model

Position	Urban (serves 80-100)	Rural (serves 42-50)
Team Leader	1 FTE	1 FTE
Psychiatric Prescriber	16 hours per 50 consumers	16 hours per 50 consumers
Registered Nurse	3 - 5 FTE	1.5 - 2 FTE
Peer Specialist	1 FTE	1 FTE
Master's level*	4 FTE	2 FTE
Other level*	1 – 3 FTE	1.5 – 2.5 FTE
Program Assistant	1 – 1.5 FTE	1 FTE

*** Within the Master's/Other Level staff are 1 FTE Vocational Specialist and 1 FTE Substance Abuse Specialist.**

Team Approach & Shared Caseload

- No individual caseloads
- Team shares responsibility for all consumers on the team
- Allows for more continuity of care
- Multiple perspectives
- Capacity to match consumer needs to various staff

Specific Admission Criteria

- Severe and persistent mental illness
  - Priority typically given to schizophrenia-spectrum disorders and bipolar disorder
- Significant difficulty with tasks needed to live independently in the community
  - e.g., maintaining employment and/or housing, care for medical or nutritional needs, meeting financial needs
- Continuous high service needs
  - e.g., high use of inpatient or crisis services, long duration of substance use, criminal justice involvement

Primary Provider of Services

- PACT does not broker services
- All services directly provided by the team
- Range of disciplines and cross-training make this possible

Comprehensive Care

- Conduct broad, strengths-based assessment to determine full range of service needs
- Full range of services
- Services are available 24 hours a day, 7 days a week

Intensive Services

- Available to meet individual needs
  - Multiple times a day/week
  - As many hours as needed
- Frequency and duration are adjusted to meet individual needs
- Low staff-to-consumer ratio (1:10) facilitates both level of intensity and individual approach

Services Provided In-Vivo

- Not a traditional outpatient or office-based approach
- Team works with individuals in their homes and communities
- Both to do outreach and to promote skills generalization in real world settings

Individualized Services

- Not a “one size fits all” approach to services
- Services are driven by individual needs
- Ties back to various disciplines available to provide a range of services

Assertive, Yet Flexible

- Assertive outreach and engagement
- Does not mean “aggressive” or “coercive”
- Prevents individuals from falling through the cracks

Open-Ended Services

- Individuals can receive services from PACT for as long as is needed
- Individuals who graduate can be readmitted to the team if needed
- Focus is on facilitating recovery and graduating from PACT

Person-Centered & Recovery-Oriented

- Strengths-based assessment
- Person-centered planning
- Individualized services
- Consumer choice is essential
- Should not foster dependency or be coercive

Work with Natural Supports

- An individual does not function within a vacuum
- Individuals' families and/or other natural supports are essential to engage
- Provide education, consultation, and support as needed

Range of PACT Services

- Service coordination
- Crisis assessment & intervention
- Integrated co-occurring disorders treatment
- Vocational services
- Peer support
- Wellness management & recovery
- Working with families & natural supports
- Symptom assessment & management
- Medication prescription, administration, monitoring
- Housing acquisition and maintenance
- Activities of daily living
- Community & social integration

PACT has been widely promoted

- **1996:** NAMI began promoting PACT in all 50 states
- **1998:** Recommended by Schizophrenia PORT Study. Identified as one of six Evidence-Based Practices (EBPs) by RWJ expert panel.
- **1999:** Promoted by the U.S. Surgeon General. HCFA (now CMS) authorized PACT as a Medicaid-reimbursable service.
- **2000-2005:** Focus within the National EBP Project, SAMHSA Toolkits and 1 of 3 indicators of quality in state mental health systems, President's New Freedom Commission.
- **Today:** Efforts to ensure that PACT is implemented as intended. Person-centered & recovery-oriented approaches are front & center.

PACT Dissemination

- 1996: 396 PACT Teams in 34 states
  - Early adopters: WI, RI, DE, NH, CT, SC, MI
  - Recent adopters: IL,TX, NJ, NY,FL (Meisler, 1996)
- 2003: 36 (out of 48 responding) states funded or operated approximately 440 total PACT or PACT-like programs.
  - Range per state = 1 (LA, OR, WA) to 72 (NY)
  - Median per state = 7 PACT programs

(NASMHPD, 2004)

PACT Dissemination (cont.)

- 2003: 41 (out of 48 responding) states reported providing PACT or PACT-like services
  - 11 states: statewide
  - 27 states: implemented in parts of state
  - 6 states: piloted or planned (NASMHPD, 2004)
- Exemplary programs in 2007:
  - Oklahoma
  - Madison and Green County, WI

International PACT Dissemination

- Australia
- Canada
- England
- Sweden
- Holland
- And now most recently…Japan

Does PACT work?

PACT has been widely studied

- Over 50 published empirical studies -- at least 25 are RCTs
- Several reviews and meta-analyses of PACT research
- Studies vary on details regarding “what” was actually delivered
- All indicate some degree of improved community integration for PACT clients

What the data say across studies

- PACT's most robust outcomes:
  - ✓ Decreased hospital use
  - ✓ More independent living & housing stability
  - ✓ Retention in treatment
  - ✓ Consumer and family satisfaction

- Moderate outcomes:
  - ✓ Reduced psychiatric symptoms
  - ✓ Improved quality of life

Weaker evidence in these areas

- Vocational improvement/employment
- Social adjustment/functioning
- Substance use
- Criminal justice system involvement

Suggests the need for targeting these areas in PACT service delivery – significant implications for ongoing training

Cost-effectiveness of PACT

- Original PACT study
  - Small economic advantage over hospital-based care (Weisbrod, Test, & Stein, 1980)
- Latimer (1999) reviewed 34 PACT programs and found that PACT is cost-effective when:
  - Services are targeted toward persons who are high users of inpatient psychiatric services (>50 hospital days in prior year)
  - It is implemented with high fidelity to the PACT model

What consumers say about PACT

- What do they like?
  - Helping relationship & staff attributes were highest endorsed
  - Team approach seldom mentioned
  - Therapeutic relationship related to consumer satisfaction

(McGrew et al., 1996)

- What do they dislike?
  - Most disliked “nothing”
  - PACT-specific issues
  - Insufficient PACT
  - More general complaints about system
  - The higher the fidelity, the fewer the complaints

(McGrew et al., 2002)

What PACT providers say about PACT

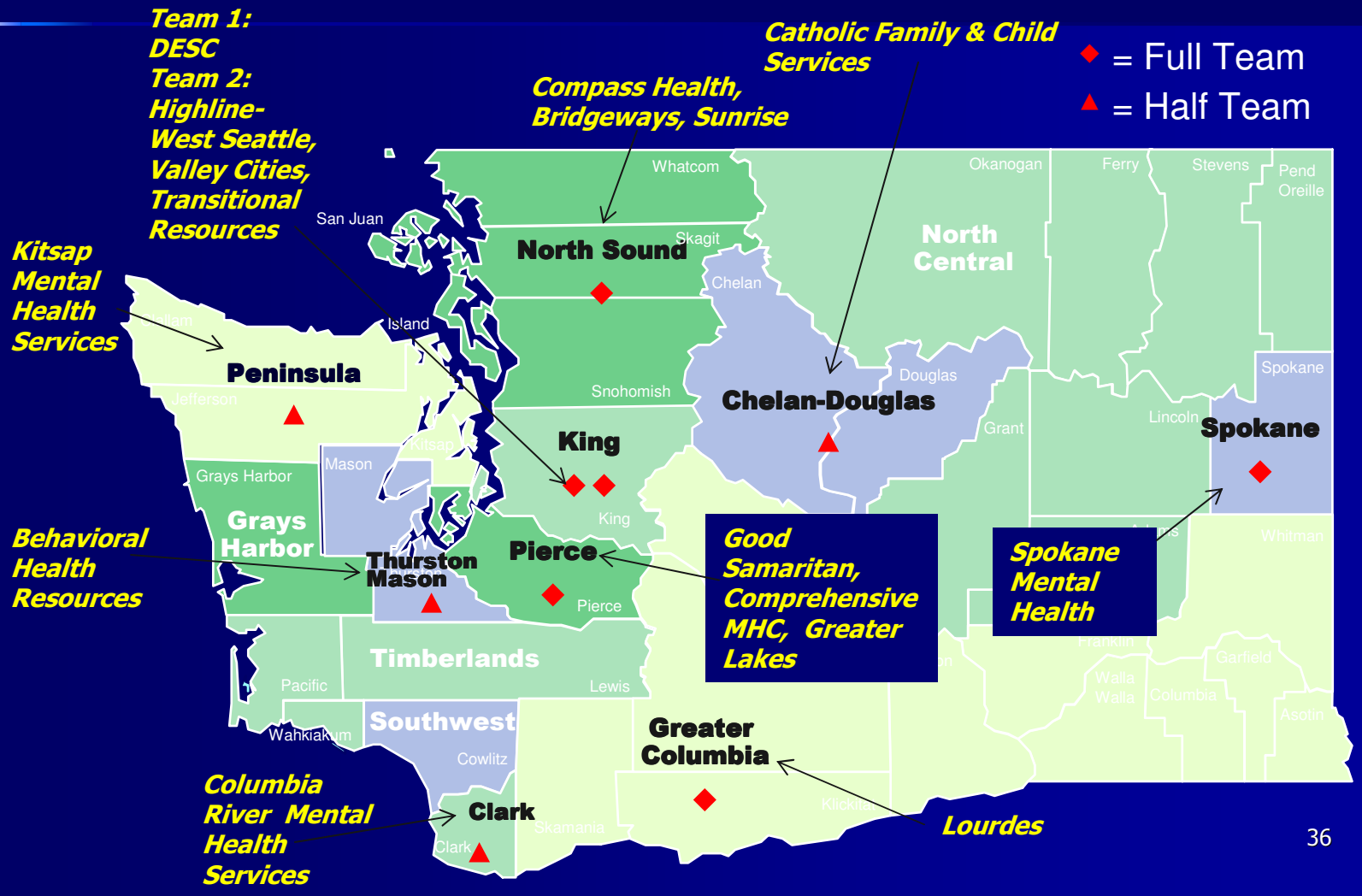
- Top 10 ingredients:
  - Nursing role is helpful
  - Involvement in hospitalization
  - FT social work-type role to help with daily needs
  - Shared treatment planning
  - Small caseloads/low staff-consumer ratio
  - Services in community
  - Clearly identified admission criteria
  - Daily meetings (McGrew & Bond, 1997)
- PACT provider burnout (vs. case manager):
  - Less emotional exhaustion
  - More personal accomplishment (Boyer & Bond, 1999)

WA-PACT Implementation

Policy Context for WA-PACT

- Washington State legislature funding
  - $2.2 million for development/training in FY 07
  - $10.4 million per year to implement 10 new PACT teams statewide
- Expected reduction in state hospital beds
- Of the 10 teams:
  - 6 full/urban teams (serving 80-100 consumers)
  - 4 half/rural teams (serving 42-50 consumers)
- Western teams by July 1; Eastern teams by Oct. 1

WA-PACT RSNs & Selected Providers



Training & Technical Assistance (May - June 2007)

- Core Training Modules:
  - PACT Start-Up
  - Core Content Areas and Skills Training
- Ongoing Technical Assistance:
  - Ongoing Team Development
  - Case-Based Consultation
  - Housing Needs
- Build training plan post June 30th based on feedback on ongoing training needs

WA-PACT
Fidelity Monitoring

What is Program Fidelity?

...the extent to which program practices adhere to the principles of the intended program model

- Necessary to ensure internal validity
- Critical for replication
- Essential for true interpretation of outcome
- Identify/prevent model drift
- Useful for program monitoring

The Value of PACT Fidelity

- Consumers and staff in PACT programs with greater fidelity experienced better outcomes
- In McGrew, Bond, et al. (1994), reduced hospital use was correlated with:
  - Shared caseloads
  - Nurse on team
  - Daily team meetings
  - Team leader as practicing clinician
  - Total contacts

The Value of PACT Fidelity

- Examined consumer outcomes in 7 PACT teams
- Consumers served by high fidelity PACT teams experienced:
  - Fewer hospitalizations
  - Fewer treatment dropouts
  - Greater remission from substance use

McHugo, Drake, et al., 1999

The DACTS (Teague et al., 1998)

- 28 items
- Anchored ratings between 1 (“not implemented”) and 5 (“fully implemented”)
- Examines structure, staffing, organizational components, and nature of services
- Ratings based on *current* activities and status
- Typically completed by external reviewers or agency staff

DACTS Example Item

Domain	1	2	3	4	5
Responsible for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

Limitations of the DACTS

- Mainly assesses structure vs. processes or principles within the team
- Original purpose to assess a COD-ACT team
- Doesn't match up with National PACT Program Standards (i.e., WA-PACT Standards)
- Includes virtually nothing about person-centered, recovery-oriented processes

Approach to WA-PACT Fidelity Assessment

- Use the DACTS template and approach
  - Utility in using an anchored scale vs. “is it there or not” approach
  - Much about the existing DACTS is useful
  - Many other states still use the DACTS -- only scale out there
- Crosswalk WA-PACT Standards with DACTS
  - Modification to some domains/anchors on staffing
  - More clarity in domains identified as problematic

Next Steps on WA-PACT Evaluation

- Finalize pilot fidelity tool by July 1, 2007
- Orient and pilot WA-PACT fidelity scale with Western teams through summer 2007
- Ongoing onsite fidelity monitoring by WIMIRT and MHD
- Provide feedback for ongoing performance improvement
- Outcome monitoring plan by MHD in coming months

For More Information on PACT Training & TA:

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